STATE OF ARKANSAS
Department of Finance and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 http://www.state.ar.us/dfa/ebd

State Employees
Enrollment Form

1. Employee Information: (please print)				❒ I decline coverage for myself
Last Name	First Name	MI	Sex	❒ Married ❒ Single
Home Address	City	State	Zip Code	
Social Security #:	Date of Birth:	Home #:	Work #:	
If you would like benefit information sent to you by email, please print your email address:				
†Primary Care Physician:	PCP #	Current patient?		

†Primary Care Physician lines are applicable for HMO and POS enrollees only, not PPO.

2. Dependent Coverage Information:			❒ I decline coverage for my dependents
SPOUSE			
FIRST NAME	LAST NAME	MI	SEX
Social Security #:	Date of Birth:		
†Primary Care Physician:	PCP #	Current patient?	
DEP 1*			
FIRST NAME	LAST NAME	MI	SEX
Social Security #:	Date of Birth:	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	
DEP 2*			
FIRST NAME	LAST NAME	MI	SEX
Social Security #:	Date of Birth:	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	
DEP 3*			
FIRST NAME	LAST NAME	MI	SEX
Social Security #:	Date of Birth:	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	
DEP 4*			
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply
**For dependents 19 and over only. Please submit proof of student status.

3. I Wish To Enroll In The Following Plan:		
H.M.O	P.O.S.	P.P.O
❒ Health Advantage ❒ QualChoice/QCA	❒ Health Advantage ❒ QualChoice/QCA	❒ Arkansas Blue Cross and Blue Shield
❒ Employee Only ❒ Employee & Spouse ❒ Employee & Children ❒ Family		

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? ❒Yes ❒No
2) If Yes, what type of coverage? ❒ Medical ❒ Medicare, HIC # _____
If Medicare: Part A Effective Date / / or Part B Eff Date / /
If Medicare: Reason for Coverage: ❒ Over age 65 ❒ Disabled ❒ Kidney Disease
Please make sure EBD and your carrier has a copy of your Medicare card.
If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. To Be Completed By Agency:

Agency #:	Name of Agency	
Employee #:	Hire Date:	Effective Date of Coverage:
If employee is transferring from another agency, please provide name:		

Insurance Representative Signature: _____

Print Name: _____

6. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand that if I refuse to apply now and I apply for coverage at a later date, my request may be deferred until open enrollment.

Employee's Signature: _____ **Date:** _____